

Medicaid

Medicaid Matters New York

Matters

1115 Medicaid Demonstration Waiver NYS Department of Health Amendment Application Fact Sheet and Advocacy Information

About the 1115 Waiver:

- Agreement between the Federal Centers for Medicare and Medicaid Services (CMS) and New York State that allows the State to administer Medicaid Managed Care
- Referred to as the “1115 Waiver” because the authority for such a waiver is provided under Section 1115 of the Federal Social Security Act
- Referred to in New York State as the “MRT Waiver” (MRT stands for Medicaid Redesign Team); previously referred to as “the New York Partnership Plan”
- Vehicle by which the State has implemented the initiatives of the Medicaid Redesign Team and all subsequent health systems reforms, including the Delivery System Reform Incentive Payment (DSRIP) program
- The MRT Waiver was approved in December 2016; the State was previously operating on several extensions of the last approved version in 2014
- More information about the MRT Waiver is available on the DOH website at [this link](#).

Find general information and background on 1115 waivers [here](#), from the Kaiser Family Foundation.

NYS application for an amendment to the 1115 waiver:

- Titled *Strategic Health Equity Reform Payment Arrangements: Making Targeted, Evidence-Based Investments to Address the Health Disparities Exacerbated by the COVID-19 Pandemic*
- Submitted as a [draft](#) to CMS on April 13, 2022

Resources, summaries and commentary on the amendment application:

Summary by [Denise Soffel](#), long-time Medicaid consumer advocate working with Medicaid Matters

Summary and commentary by [Judy Wessler](#), long-time Medicaid consumer advocate who has done advocacy work on several 1115 waivers

[Summary of what changed](#) between the concept paper submitted in 2021 and the draft application, by Kalin Scott of Helgerson Solutions Group

Archived webinar and slides providing summary information by [Health Management Associates](#)

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This document is subject to revision as we continue our analysis and deepen our discussion on the impact the waiver will have on New Yorkers served by Medicaid.

Manatt Health [issue brief](#) on Medicaid 1115 waivers and how they can address health equity

Public comment:

The Special Terms and Conditions of the 1115 waiver dictated by CMS require the State to solicit public comments on the State's amendment application.

The second of two virtual public comment sessions is scheduled for May 10, 2022, 1:00-4:00. You must register to receive the link to watch the webcast. If you wish to provide comments at the public comment session, send an email by May 9, 2022 at 4:00 to 1115waivers@health.ny.gov, and put SP in front of your name in the subject line.

Written public comments must be submitted by May 20, 2022 (extended from the original deadline of May 13). Submit comments by email to 1115waivers@health.ny.gov

Medicaid Matters perspective:

Overall, Medicaid Matters supports the goal of infusing the Medicaid program with new funding with the intention of reaching greater health equity. As Medicaid consumer advocates, our interest is in:

- making sure the intended health equity outcomes are reached;
- seeing New Yorkers experience greater access to services and achieve better health and wellness; and
- that public Medicaid funds are not squandered or treated as a payout to the managed care insurance industry and well-financed providers.

Many groups and organizations will provide comments from their own unique perspectives. Medicaid Matters urges the State to carefully consider their comments on the waiver, as they bring expertise and experience specific to certain aspects of the waiver (such as working with people who are or were incarcerated, for instance).

Issues Medicaid Matters urges NYS to consider:

Lessons learned from the Delivery System Reform Incentive Payment (DSRIP) program (the last amendment to the NYS 1115 waiver, which expired March 2020)

- The Health Equity Regional Organizations (HEROs) described in the new waiver application would include a variety of stakeholders, including consumer representation. This should be written as a requirement and should specify consumers, consumer advocates and community members separately.
- Community-based organizations (CBOs) must be financially supported to enable and foster their participation and service provision under the new waiver. CBOs will need compensation for staff time, in addition to funding for IT systems, consulting services, and infrastructure.
- Flow of funding must be as transparent as possible. The public must be able to track the funding the State receives all the way down to the entities that receive it.

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- Independent oversight must be established as part of the new waiver. This function was fulfilled under DSRIP by the Project Approval and Oversight Panel (PAOP). Any independent oversight body should include robust and diverse consumer and community representation from across the state (more so than the PAOP), and it should convene regularly in public meetings with opportunities for public comment. It is critical that data reports be shared before they are too stale to make changes to the program.

Managed care as the focus

- Under the State's new waiver design, community-based organizations and providers would be providing a variety of services that managed care plans currently get paid for in their capitation, like care coordination. Managed care plans must be held accountable for the delivery of meaningful care coordination and other functions they are paid to carry out. The State should match compensation to the entities actually doing the work; CBOs should get paid more and upfront and regular managed care capitation rates should be decreased for plans no longer doing the work they are paid to do under their capitation.
- The new waiver design has the potential for creating care management siloes, with some care management continuing at the plan level and some being carried out by CBOs providing social care. People must understand who is ultimately responsible for their services and who to turn to when they need help.
- Independent consumer advocacy services should be expanded and adequately supported to provide assistance to people who need help navigating a new environment of value-based care.
- It is unclear how people who are covered by Medicaid but not enrolled in managed care will benefit from value based payment arrangements. The State must articulate how health equity will be reached for these groups of people.
- Medicaid managed care plans do not universally have a good track record for providing the services people are entitled to. Plans are often seen by consumers as a barrier. The State should invest in better oversight of managed care plans to restore trust and ensure greater access to services.

Meaningful ways to reach greater health equity

- "Equity" must be clearly defined; consumer representatives and community members must be included in reaching a shared, agreed upon definition. Agreed upon definitions may draw from work already done in this area by groups such as [Unidos US](#).
- The waiver application proposes statewide standards for data collection and availability and statewide and regionally-specific sets of health equity-specific quality improvement measures. It does not, however, identify the entities that will determine what those measures are or how they would be prioritized. Specificity must be built in, and consumers and consumer advocates must be part of that process.
- Non-clinical outcomes (i.e. vaccination rates, timely prenatal care visits, accessibility of consumer-facing materials) should be weighed as heavily as clinical outcomes.

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- It is critical to collect and report disaggregated data. [California](#), [Massachusetts](#), [New Jersey](#), and [Oregon](#) have recently submitted 1115 waiver applications calling for disaggregation of data by race and ethnicity and in some areas by other subgroups as well. A [new Florida law](#) requires managed care plans to stratify and publicly report performance data by age, race, ethnicity, primary language, sex, and disability (beginning in 2026).
- The call for improved Medicaid data collection and reporting on health disparities is not new. There may be potential in CMS' new data reporting system, T-MSIS, for improving the quality, frequency, and transparency of health disparities data in Medicaid, [along with other approaches](#) (from the National Health Law Program, May 2021).
- Include incentives for avoiding nursing home placements (like the incentives in DSRIP for avoiding hospitalization); incorporate metrics related to compliance with the *Olmstead* decision, which entitles people to services in the most-integrated setting in the community.